

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



July 24, 2001

ALL COUNTY INFORMATION NOTICE. I-60-01

TO: ALL COUNTY WELFARE DIRECTORS
ALL CalWORKs PROGRAM SPECIALISTS
ALL COUNTY FORMS COORDINATORS
ALL FOOD STAMP COORDINATORS
ALL COUNTY SFIS COORDINATORS

REASON FOR THIS TRANSMITTAL

☒ State Law Change
☐ Federal Law or Regulation Change
☐ Court Order
☒ Clarification Requested by one or More Counties

SUBJECT: REVISED CalWORKs FORMS: CW 2.1 Q, CW 5, CW 7A, CW 8, CW 10, CW 25, CW 25A, CW 30, CW 42, CW 51, CW 81, CW 371, M20-003, M20-003A, M44-211L, M44-211N

REFERENCE: ASSEMBLY BILL (AB) 1542, CHAPTER 270, STATUTES of 1997, ACL 00-32 (SFIS) AND ACL 00-45 (PREGNANCY SPECIAL NEEDS)

This All County Information Notice (ACIN) transmits copies of the revised versions of the following forms and new or revised Notice of Action (NOA) messages for the California Work Opportunity and Responsibility to Kids (CalWORKs) Program:

Forms

CW 2.1 (Q) Support Questionnaire
CW 5 Veteran's Benefits Verification and Referral
CW 7A How to Fill Out your CW 7 and SAWS 7
CW 8 Statement of Facts for an Additional Person
CW 10 Notice of Withdrawn Application
CW 25 Supplemental Statement of Facts – Minor Parent
CW 25A Payee Agreement for Minor Parent
CW 30 CalWORKs Budget Worksheet
CW 42 Statement of Facts – Homeless Assistance
CW 51 Child Support – Good Cause Claim for Noncooperation
CW 81 Lien Agreement
CW 371 Referral to Local Child Support Agency (LCSA)

NOA Messages

M20-003 SFIS – Duplicate Aid Match (Discontinue)
M20-003A SFIS – Duplicate Aid Match (Deny)
M44-211L Pregnancy Special Needs (Special Needs)
M44-211N Pregnancy Special Needs (No Longer Pregnant)

Revised Forms

The CalWORKs forms are revised to conform to CalWORKs eligibility requirements. Changes have also been made to improve clarity and organization of the forms. Counties should begin using the revised forms as soon as administratively feasible.

Notice of Action Messages

The two new NOA messages transmitted with this ACIN, NOA messages M20-003 and M20-003A, are to deny or discontinue aid when a duplicate aid match is found through the Statewide Fingerprint Imaging System (SFIS). Duplicate aid matches must be verified as potential or actual fraud before denying or discontinuing aid. It is imperative that counties take precautions to ensure that aid is not denied or discontinued due to SFIS “clerical” or “system” error. These NOA’s are not intended to replace existing notices/forms used for Intentional Program Violations.

As noted above, this ACIN also transmits revised NOA messages regarding pregnancy special needs. ACL 00-45, issued on July 13, 2000, provided instructions to counties with regard to payments of pregnancy special needs supplemental grants. NOA message M44-211L has been revised to correlate with the changes to these payments. NOA message M44-211N has also been updated to comply with current regulations and add language to inform applicants/recipients about adding a newborn to the assistance unit. Counties must begin using these NOA messages immediately.

Forms Designation and Modification of Forms

Except for the CW 5, CW 8, and CW 30, the forms transmitted with this ACIN are designated as “Required Form - Substitute Permitted.” County welfare departments (CWDs) must obtain prior approval from the California Department of Social Services (CDSS) and/or the Department of Health Services (DHS) before implementing a modification or substitution to these and other “Substitute Permitted” forms. For CalWORKs and Food Stamp program changes, the procedures for submission of a change request are outlined in the Management and Office Procedures Regulations 23-400.22 and the Food Stamp Handbook Regulations 63-1250. For Medi-Cal changes or DHS substitutions, CWDs should forward requests to the Medi-Cal Eligibility Branch. The CW 5 is designated as a “Required Form – No Substitute Permitted,” and forms in this category may not be modified or reconstructed. The CW 8 and CW 30, are designated as “Recommended”; CWDs may modify forms in this category and may choose to not use them.

Camera-Ready Copies and Translations

After you receive a copy of an English CalWORKs form, or a NOA message/form, please allow six to eight weeks for the form or NOA message to be translated and mailed to your CalWORKs Forms Coordinator. Language Translation Services (LTS) will mail camera-ready copies of Spanish, Chinese, Vietnamese and Russian translations as soon as they become available. You do not need to initially request forms or messages from LTS. To order additional camera-ready forms or messages in Spanish, Chinese, Vietnamese or Russian, fax your request to LTS at (916) 657-3429 or e-mail it to LTS@dss.ca.gov.

For a camera-ready copy and/or an additional copy of an English form (not NOA messages), please call the Forms Management Unit (FMU) at (916) 657-1907. If your office has Internet access, you may obtain various forms (not including NOA messages) from the CDSS web page at: www.dss.cahwnet.gov. FMU is currently in the process of making forms available on the Internet. If the name, mailing address or e-mail address of your CalWORKs Forms Coordinator changes, please contact FMU by telephone at (916) 654-1282 or by e-mail to fm@dss.ca.gov. For additional copies of NOA messages, please contact Terry Mallin at (916) 653-8395 or e-mail her at: terry.mallin@dss.ca.gov.

Your CalWORKs Forms Coordinator is to distribute translated forms and messages to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code Section 7290 et seq) and by the state regulations in Manual of Policies and Procedures (MPP) Division 21, Civil Rights Nondiscrimination, Section 115.

Stock

State produced stock of the English and Spanish language versions for the attached forms will be available 30 to 60 days after the release of this letter. Stock of each CalWORKs form may be ordered from the CDSS Warehouse upon receipt of the Notice of Form Change (GEN 127), in accordance with the procedures in the County Forms Catalog. NOA messages are not available from the CDSS Warehouse.

Contacts

If you have any questions or need further information regarding this letter, please contact the following staff regarding the specific program areas:

Letter: Jackie Shelley @ jackie.shelley@dss.ca.gov,
(916) 654-1061 or CALNET (916) 454-1061

Forms and NOA messages: Terry Mallin @ terry.mallin@dss.ca.gov,
(916) 653-8395 or CALNET (916) 453-8395

Food Stamp Program: Sandra Pierce at (916) 653-6208 or CALNET 453-8208

Child Support Services: Myrna Gregory at (916) 464-5229 or CALNET 433-5229

CalWORKs Child Support: Ruth Van Den Berg at (916) 654-1786 or CALNET 454-1786

Asian/Spanish translations: Tuyet Hoang at (916) 654-1282 or CALNET (916) 454-1282

Medi-Cal: Alice Mak at (916) 654-0573 or CALNET (916) 454-0573

Sincerely,
Original signed by
Maria Hernandez for Charr Lee Metsker on
July 24, 2001
CHARR LEE METSKER, Chief
Employment and Eligibility Branch

Attachments

c: CWDA
CSAC

SUPPORT QUESTIONNAIRE

Instructions:**You must answer ALL questions.****COMPLETE ONE FORM FOR EACH NONCUSTODIAL PARENT OR EACH UNMARRIED FATHER IN THE HOME.**Use ink. Print answer. Check Yes, No, or Unknown.
Use a separate piece of paper if you need more room.**SECTION 1 - COMPLETE THE FOLLOWING ABOUT YOURSELF**

NAME (FIRST, MIDDLE, LAST)	MAIDEN NAME	SOCIAL SECURITY NUMBER (SSN)	BIRTHDATE	BIRTH PLACE	RACE
HOME ADDRESS (STREET NUMBER AND NAME, APARTMENT NUMBER, IF ANY)		CITY	STATE	ZIP	TELEPHONE NUMBER ()
YOUR RELATIONSHIP TO CHILDREN		YOUR RELATIONSHIP TO ABSENT PARENT/UNMARRIED FATHER IN THE HOME <input type="checkbox"/> Spouse <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Other			

SECTION 2 - COMPLETE THE FOLLOWING ABOUT THE NONCUSTODIAL PARENT OR UNMARRIED FATHER IN THE HOME

A. NAME (FIRST, MIDDLE, LAST)		SOCIAL SECURITY NUMBER (SSN)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTHDATE	BIRTH PLACE
LAST KNOWN ADDRESS (STREET NUMBER AND NAME, APARTMENT NUMBER, IF ANY)		HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	RACE
CITY	STATE	ZIP	SCARS, BIRTHMARKS, TATTOOS, NICKNAMES, ETC.			
WHEN WAS THIS ADDRESS CURRENT?	TELEPHONE NUMBER ()	WHEN DID YOU LAST HEAR FROM OR GET MAIL FROM THIS PARENT?			DOES THIS PARENT LIVE WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
B. WHAT KIND OF INCOME DOES NONCUSTODIAL PARENT HAVE? <input type="checkbox"/> Earnings <input type="checkbox"/> Unemployment or Disability Insurance Benefits <input type="checkbox"/> Social Security <input type="checkbox"/> None <input type="checkbox"/> Other						
LAST KNOWN EMPLOYER		TELEPHONE NUMBER ()				
STREET ADDRESS		TYPE OF WORK				
CITY	STATE	ZIP	UNION MEMBER? <input type="checkbox"/> YES, UNION NAME <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			
WHEN DID THIS PARENT LAST WORK THERE?		UNION ADDRESS:				
C. DOES THIS PARENT HAVE HEALTH INSURANCE FOR THE CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WHO IS COVERED?				
NAME OF INSURANCE		POLICY NUMBER			DATE OF COVERAGE	
D. PARENTS ARE OR HAVE BEEN <input type="checkbox"/> MARRIED DATE _____ WHERE _____ <input type="checkbox"/> DIVORCED DATE _____ WHERE _____ <input type="checkbox"/> SEPARATED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> LIVING TOGETHER						
E. IS THERE A COURT ORDER FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING		AMOUNT ORDERED \$	HOW OFTEN?	DATE OF COURT ORDER	COURT ORDER NUMBER	LOCATION OF COURT (COUNTY & STATE)
HOW DOES THE PARENT PAY? <input type="checkbox"/> PAYS HOUSEHOLD BILLS <input type="checkbox"/> TO YOU <input type="checkbox"/> TO COUNTY <input type="checkbox"/> PAYROLL DEDUCTION <input type="checkbox"/> OTHER		WHEN DID PARENT LAST PAY?			HOW MUCH? \$	
F. NAME OF A FRIEND OR RELATIVE OF NONCUSTODIAL PARENT		RELATIONSHIP TO NONCUSTODIAL PARENT			TELEPHONE NUMBER ()	
ADDRESS (NUMBER AND STREET)		CITY			STATE	ZIP
G. DOES THIS PARENT OWN ANY MOTOR VEHICLES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		MAKE	MODEL	YEAR	LICENSE NO.	STATE
H. DOES THIS PARENT OWN A HOUSE, LAND, BUILDINGS, OR BANK ACCOUNTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WHAT/WHERE				
I. IS THIS PARENT CURRENTLY ON PROBATION OR PAROLE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WHAT COUNTY OR STATE?				
J. HAS THIS PARENT EVER BEEN IN JAIL OR PRISON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		IF YES, WHEN/WHERE?				
K. HAS THIS PARENT EVER BEEN IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		IF YES, WHEN/WHAT BRANCH?				
L. ARE YOU ABLE TO IDENTIFY OR HELP LOCATE THE NONCUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						

SECTION 3 - CHILDREN (IN YOUR HOME) OF THIS PARENT OR UNMARRIED FATHER

NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE - -	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> DATE SIGNED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK COUNTY
NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE - -	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> DATE SIGNED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK COUNTY
NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE - -	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> DATE SIGNED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK COUNTY
NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE - -	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> DATE SIGNED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK COUNTY

SECTION 4 - SUPPORT ENFORCEMENT SERVICES (MEDI-CAL ONLY)☐ I don't want other child support enforcement services.**I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA THAT THE INFORMATION IN THIS QUESTIONNAIRE IS TRUE, CORRECT AND COMPLETE.**

SIGNATURE 	DATE
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VETERANS BENEFITS VERIFICATION AND REFERRAL**NOTE: Do not complete this form unless one of the following is known:**

- **Veterans Social Security Number and Date of Birth**
- **Military Serial Number**
- **Veterans Administration (VA) Claim Number**

You and any member of your household for whom you are applying for aid must give us the Social Security Number(s) (SSN). The SSN(s) are used to determine your eligibility and failure to cooperate may result in denial or discontinuance of aid. Authority: 45 Code of Federal Regulations Section 205.52, and Welfare and Institutions Code Section 11268(a).

Name and Address of County Veterans Service Office

CASE NAME:
CASE NUMBER (INCLUDING MEDS AID CODE):
APPLICANT/RECIPIENT PHONE #:
CASE WORKER:
WORKER PHONE #:

SECTION I

VETERAN'S NAME (LAST, FIRST, MIDDLE)		BIRTH DATE:	BIRTHPLACE:	LIVING? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF DECEASED: DATE OF DEATH: PLACE OF DEATH:
VETERAN'S ADDRESS: (NUMBER, STREET, CITY, STATE, ZIP CODE)			DOES THIS VETERAN LIVE IN YOUR HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO	VA CLAIM NUMBER: SOCIAL SECURITY NUMBER: MILITARY SERIAL NUMBER:	
BRANCH OF SERVICE:		DATE OF ENTRY:	DATE OF DISCHARGE:	TYPE OF DISCHARGE: <input type="checkbox"/> HONORABLE <input type="checkbox"/> GENERAL <input type="checkbox"/> MEDICAL <input type="checkbox"/> OTHER THAN HONORABLE <input type="checkbox"/> UNKNOWN	
VETERAN'S MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED		IS THIS VETERAN PERMANENTLY UNABLE TO WORK BECAUSE OF DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THIS VETERAN SUFFER AN IN-SERVICE UNJURY OR ILLNESS THAT CAUSES A CURRENT DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
VETERAN'S GROSS MONTHLY INCOME: \$		IS ANYONE IN LONG-TERM CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, (✓) BELOW: <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		IS ANYONE BLIND, OR IS HOME CARE NEEDED TO FEED, BATHE, OR DRESS A HOUSEHOLD MEMBER: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, (✓) BELOW: <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
SPOUSE'S GROSS MONTHLY INCOME: \$					

SECTION II

NAME OF CLAIMANT:	RELATIONSHIP TO VETERAN:	BIRTH DATE:	SOCIAL SECURITY NUMBER:	ADDRESS:

SECTION III

I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the Veterans Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Office and Veterans Administration to release their findings (to be noted below).

SIGNATURE (OR MARK) OF VETERAN/DEPENDANT:	DATE:	SIGNATURE OF WITNESS TO MARK:	DATE:

SECTION IV (To be completed by the County Welfare Department and the County Veterans Service Office)

The County Welfare Department requests the County Veterans Service Office to:

<input type="checkbox"/> Verify any VA benefits received by the veteran and/or dependent(s):	<input type="checkbox"/> Determine veteran/dependent's eligibility for veteran's benefits:																											
<table><tr><th></th><th>1-Veteran</th><th>2-Claimant</th><th>3-Claimant</th><th>4-Claimant</th></tr><tr><td>Monthly Benefit</td><td>\$</td><td>\$</td><td>\$</td><td>\$</td></tr><tr><td>Beginning Date (Month/Day/Year)</td><td></td><td></td><td></td><td></td></tr><tr><td>Ending Date (Month/Day/Year)</td><td></td><td></td><td></td><td></td></tr><tr><td>Lump Sum Payment (Past 6 Months)</td><td>\$</td><td>\$</td><td>\$</td><td>\$</td></tr></table>		1-Veteran	2-Claimant	3-Claimant	4-Claimant	Monthly Benefit	\$	\$	\$	\$	Beginning Date (Month/Day/Year)					Ending Date (Month/Day/Year)					Lump Sum Payment (Past 6 Months)	\$	\$	\$	\$	<table><tr><td>(✓) If monthly benefit is paid, <input type="checkbox"/> Compensation <input type="checkbox"/> Pension <input type="checkbox"/> Other (see remarks) <input type="checkbox"/> Includes A & A benefits of \$_____</td><td>(✓) Eligibility status: <input type="checkbox"/> No basic eligibility <input type="checkbox"/> Claim initiated <input type="checkbox"/> Claim being reviewed <input type="checkbox"/> Claim denied</td></tr></table>	(✓) If monthly benefit is paid, <input type="checkbox"/> Compensation <input type="checkbox"/> Pension <input type="checkbox"/> Other (see remarks) <input type="checkbox"/> Includes A & A benefits of \$_____	(✓) Eligibility status: <input type="checkbox"/> No basic eligibility <input type="checkbox"/> Claim initiated <input type="checkbox"/> Claim being reviewed <input type="checkbox"/> Claim denied
	1-Veteran	2-Claimant	3-Claimant	4-Claimant																								
Monthly Benefit	\$	\$	\$	\$																								
Beginning Date (Month/Day/Year)																												
Ending Date (Month/Day/Year)																												
Lump Sum Payment (Past 6 Months)	\$	\$	\$	\$																								
(✓) If monthly benefit is paid, <input type="checkbox"/> Compensation <input type="checkbox"/> Pension <input type="checkbox"/> Other (see remarks) <input type="checkbox"/> Includes A & A benefits of \$_____	(✓) Eligibility status: <input type="checkbox"/> No basic eligibility <input type="checkbox"/> Claim initiated <input type="checkbox"/> Claim being reviewed <input type="checkbox"/> Claim denied																											
REMARKS: (For official use only)																												

Name and Address of County Human Services Office

CVSO REPRESENTATIVE: (PRINT)	PHONE #:	DATE:

INSTRUCTIONS FOR COUNTY USE AND COMPLETION OF VETERAN'S BENEFITS VERIFICATION AND REFERRAL FORM CW 5

USE THE CW 5:

1. To verify the status amount of the veteran's benefits being received.
2. To refer applicants or recipients to the County Veterans Service Office (CVSO).
3. To obtain new veteran benefits when the information on the Statement of Facts forms for the following programs indicates possible eligibility for benefits or county general assistance or relief:
 - California Work Opportunity and Responsibility to Kids (CalWORKs)
 - Medi-Cal
 - State-Run County Medical Services Program
 - Food Stamps
 - AFDC-Foster Care
 - Kin GAP
 - Healthy Families
 - Other Program Statement of Facts forms

DO NOT COMPLETE THIS FORM IF THE SERVICE PERSON IS STILL ON ACTIVE DUTY, OR NONE OF THE FOLLOWING INFORMATION IS KNOWN:

1. Veteran's Social Security Number (SSN) and Date of Birth;
2. Veteran's Military Serial Number;
3. Veterans Administration (VA) Claim Number.

If either of the above applies, **do not** initiate a CW 5. Do make an entry in the "County Use Only" section of the SAWS 2 or the MC 210 or the "ELIGIBILITY WORKER ONLY": section of the FC 2 form stating why a referral was not made and place the form in the case file.

INSTRUCTIONS FOR COMPLETION OF CW 5:

1. Enter name and address of County Veterans Service Office (CVSO) in upper left-hand corner of the address box.
2. Enter name and address of County Welfare Department (CWD) in lower left-hand address box.
3. Check the appropriate request box to verify or determine benefits.
4. Enter worker and applicant/recipient case information in upper right-hand box.

Section I - Have applicant enter all known veteran and, if applicable, claimant information. At least one is required: (a) Veteran's SSN and date of birth, (b) Veteran's military serial number, or (c) VA claim number.

Section II - Have applicant enter all claimant information.

Section III - Have the veteran, dependent/claimant of foster care representative read, sign and date the authorization statement (attach a copy of placement order in foster care cases).

Section IV - This section will be filled in by the CVSO.

DISTRIBUTION AND FILING OF THE CW 5:

Complete original and photocopy 5 copies of the form. Distribute as follows:

- Original and 3 copies to CVSO. Have the veteran, dependent/claimant, or foster care representative hand carry 4 copies of the form along with medical documents, military papers, etc, to the CVSO. Referral by mail may be used if hand carry method is not possible.
- One copy for case file to be retained until original is completed and returned to CWD by CVSO. CWD will keep the completed original CW 5 as a permanent record and discard the copy.
- A copy of the completed original will be kept by CVSO.

If Veterans Affairs Aid and Attendance Benefits have been granted to the veteran, widow or parent of the veteran, CVSO will also send a copy of the completed original to: Department of Health Services, Recovery Branch, Health Insurance Unit 105, P.O. Box 1287, Sacramento, CA 95806.

HOW TO FILL OUT YOUR CW 7 OR SAWS 7

- **Save this notice and use it to help you fill out your CW 7 (Monthly Eligibility Report) or SAWS 7 (Monthly Eligibility/Status Report).** If you need help filling out your report, tell your worker.
- **Answer each question on the report.** If you say "YES", you must give more facts and attach proof when the form asks for it. Sign and date the CW 7/SAWS 7 in item ⑨. The date you sign the CW 7/SAWS 7 must be after the last day of the report month that is shown at the top right-hand corner of your form.
- **The county uses the facts you give on your report to see if you and your household members continue to be eligible for benefits and to figure the amount of aid or benefits you should get.**

**HOW OFTEN YOU MUST COMPLETE A CW 7/SAWS 7**

You must turn in a complete CW 7/SAWS 7:

- For Cash Aid and Food Stamps: every month.
- For Medi-Cal Quarterly Reporting and State-Run County Medical Services Program (CMSP): only when the county sends or gives you one.

REPORTING FOR PERSONS WHO ARE LIVING IN YOUR HOME

If Your Family Gets Cash Aid (No Food Stamps), Report Facts for:

- All children - natural, adopted, stepchildren.
- All parents - natural, adopted, stepparents.
- Other aided relatives of the children.
- Yourself and your spouse.
- Anyone who is temporarily absent from the home.

If Your Household Gets Cash Aid and Food Stamps or Food Stamps Only, Report Facts for:

- All children
- All related adults.
- Others who buy or prepare food with you.

If You Get Medi-Cal/State CMSP, Report Facts for:

- Your children - natural, adopted, stepchildren.
- Children's parents - natural, adopted, stepparents.
- Yourself and your spouse.

REQUEST TO STOP BENEFITS

- If you ask to have your cash aid stopped, your Medi-Cal may also be stopped or changed. You may not be eligible for Medi-Cal or may need to pay a share of cost for it.
- **On the SAWS 7**, complete Part A only when you want to stop any of your benefits. Check what benefits you want stopped and tell us the date you want them stopped. You must sign and date the SAWS 7 in item ⑨.

If you choose to go off cash aid, tell your worker the reason you are stopping your cash aid. Here's why:

- After your cash aid stops, you and your child(ren) still may be eligible for Food Stamp benefits even if you are now employed. Contact your worker for more information.
- **You and/or your child(ren) may be eligible for continued no cost health coverage** depending on the reasons your cash aid stops and/or other facts in your case.
- **You and/or your child(ren) may be eligible for no cost health coverage under the Transitional Medi-Cal program (TMC)** if you go off cash aid because your earnings went up. Your family must have gotten cash aid for at least three of the last six months before cash aid stopped. You may also be eligible for TMC if your cash aid stops because you get married or your spouse returns to the home.

You can tell the worker why you want to stop your cash aid by:

- Filling out and returning your CW 7/SAWS 7 or the TMC Request Form for Working Persons, OR
- Calling the county.

FACTS YOU MUST REPORT FOR EACH QUESTION

For Item Number:

- ① Any earnings and training allowances anyone got. List the name of the person(s) who got the income/training allowances, the hours they worked, gross amount received and the actual date received. If self-employed, and if you claim actual expenses for cash aid, list all business expenses on a separate sheet of paper. If you get cash aid (and no food stamps) and you told the county you wanted to figure your business costs by using a standard 40 percent deduction of your verified income, you do not need to report your business costs.
- ② Costs for child care or for care of a disabled person or other adult while working, seeking work, or in training.
- ③ Any other money anyone got, such as: Child or spousal support, Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), Unemployment/Disability Insurance, lottery winnings, lump sum, etc. List who got the income, gross amount, and date received.
- ④ Any court ordered child support you paid and any changes to the court order. (Report for food stamps and Medi-Cal/State CMSP.)
- ⑤ Facts about any member(s) in the cash aid family or food stamp household who is avoiding or running from the law to avoid a felony prosecution, or custody or confinement after a felony conviction, or in violation of a condition of their parole or probation.

Facts about any member of the cash aid or food stamp household who has been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s). Give facts:

- **for food stamps**, for crimes and convictions after 8/22/96;
- **for cash aid**, for crimes after 8/22/96 and convictions on or after 1/1/98.

- ⑦ Facts about anyone who moves into or out of your home. If someone moves into someone else's home, explain whose home and relationship. Include temporary absences from the home.
- ⑧ Other facts that could change your eligibility or the amount of your benefits, like starting or stopping a job, school or training; changes in the balances in your checking/savings accounts; buying or selling something; a change in immigration status; a child ages 6 through 17 getting cash aid who starts or stops attending school regularly; anyone getting cash aid or food stamps who starts or stops getting IHSS (In-Home Supportive Services); or anything else. Include any changes you expect to happen in the next 30 days. If you get Food Stamps and you are disabled or age 60 or older, you **may report new** medical costs not being used to figure your current allotment. On the SAWS 7, if you get Medi-Cal/State CMSP, report medical costs that were due to an injury/accident caused by someone else.

ADDRESS CHANGE: Give us any changes in your address or phone number. If you are getting food stamps, you may be asked to provide proof of your new shelter and utility costs.

SEE OTHER SIDE FOR MORE INFORMATION

PROOF

You Must Send in Proof Only When The Form Asks for It, Such As:

- For earnings or training allowances.
- For costs for care of a child or disabled adult.
- When money or benefits start, stop, or the amount changes.
- When there is a change in the court order or the amount of court ordered child support payments you pay.
- When your health insurance starts, stops, or changes.
- If you move and get food stamps, include proof of your new housing and utility costs.
- When you get married or divorced, become pregnant, or have a baby.

Examples of Proof for Income and Training Allowances:

- Original paystubs that show the name of the employer and the person who worked, the gross amount of pay before deductions, dates of the pay period, etc.
- If self-employed: Copies of quarterly/annual income tax reports, monthly profit and loss statements, etc.
- Copies of checks, award letters, loan papers, or other papers that show where the money came from, the amount owed or received, and the name of the person who got or will get the money, benefit, or free item, such as housing or utilities.

Examples of Proof for Expenses/Costs:

- **If self-employed:** copies of signed receipts, cancelled checks, statement(s) of charges from the person/firm providing an item(s) or service(s).
- **For care** of a child, or other dependent so someone can go to work or training: attach copies of receipts, bills, or cancelled checks that show the cost of the care and the names of the persons who received care, who paid for the care, and who gave the care.
- **For housing and utility costs:** receipts or bills for rent, mortgage payment; insurance and property taxes when they are not part of your mortgage payment; heating, cooling, phone bills, etc.
- **For college or trade school:** copies of statement(s) from school or an award letter showing financial aid, tuition, fees, and other school costs.

Examples of Other Proof:

- **For pregnancy:** copy of the doctor's or clinic's statement that gives the mother's name and the date the baby is due.
- **For changes in citizenship/immigration status:** a copy of a letter, form, or new card from the Immigration and Naturalization Service (INS).
- **For marriage or divorce:** a copy of a marriage license or divorce papers.

WHO MUST SIGN THE REPORT

- **For Cash Aid:** you and your aided spouse and/or the other parent (of the aided child(ren)) if living in the home.
- **For Food Stamps:** the head of household, an adult household member, or the household's authorized representative.
- **For Medi-Cal/State CMSP:** the applicant, applicant's spouse or the person acting for the beneficiary.
- **And** any other person who fills out the report, an interpreter, or the witness to your mark.

WHAT WE MEAN WHEN WE SAY

AVOIDING OR RUNNING FROM THE LAW TO AVOID PROSECUTION, OR CUSTODY OR CONFINEMENT: A person is considered avoiding or running from the law if an arrest warrant has been issued and the person knew or should have known from the facts that the law was looking for them.

CASH AID: CalWORKs (California Work Opportunity and Responsibility to Kids) and Refugee Cash Assistance.

CONTROLLED SUBSTANCE: Any drug whose availability is restricted by federal or state law, including, but not limited to, narcotics, stimulants, depressants, hallucinogens, and marijuana.

COMPLETE CW 7/SAWS 7: A CW 7/SAWS 7 is "complete" only when:

- all the YES/NO questions are answered, **and**
- all the information is filled in, **and**
- all proof is attached when the form asks for it, **and**
- all required signatures are on the form, **and**
- the form is signed and dated after the last day of the report month.

COURT ORDERED CHILD SUPPORT: The payment a legal document or court of law says you must make to a person for a child who is not in your home. Include payments made by a stepparent.

GROSS AMOUNT: The amount of your paycheck before deductions are taken out for taxes, social security, etc.

IN VIOLATION OF PAROLE OR PROBATION: Parole/probation was revoked or an arrest warrant was issued. The original crime for which parole/probation was ordered could be for a felony or misdemeanor.

REPORT MONTH: The month shown at the top right-hand corner of page one of the CW 7/SAWS 7.

STATE CMSP: Medically necessary benefits for eligible adults who are not eligible for Medi-Cal and who live in some rural counties.

CERTIFICATION SECTION

- You sign the report "under penalty of perjury." This means that you swear under oath that the facts you give us are true, correct, and complete.
- Perjury and Fraud are crimes. If **on purpose** you give us facts that are not true, correct, and complete, you will be investigated for fraud and:
 - You can be legally prosecuted with penalties of a fine, jail/prison, or both. You can be charged with a felony if you get more than \$400 in cash and/or benefits wrongly paid out to you.
 - Your cash aid and food stamps can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, or forever. **See the penalties for cash aid and food stamp welfare fraud in the Certification section on your CW 7/SAWS 7.**
 - You may have to pay back any cash aid, food stamps, or Medi-Cal/State CMSP you should not have gotten.

DO NOT FORGET!

- **If your report is late, not complete, or not turned in, your benefits may be late, changed or stopped.**
- **If your report is not complete when you turn it in, you will be asked to complete it again.**
- **If you sign and date your report before the last day of the report month, you will be asked to sign and date it again.**
- **If you are not sure how to report, what to report, or what proof you need to send in, ask your worker.**
- **If your cash aid stops, you may still be eligible for Food Stamp benefits even if you are now employed.**
- **If your cash aid stops, you may still be eligible for no-cost or low-cost health coverage under Medi-Cal.**

STATEMENT OF FACTS FOR AN ADDITIONAL PERSON*(Supplemental Application for Food Stamps and Request for Cash Aid)*

INSTRUCTIONS: Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "FS" for food stamps listed to the left side of each question tell you which questions are for which program.

If you get cash aid, and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

For Food Stamp households, which do not get cash aid or do not want cash aid for the new person, this form may be completed by a household member, an authorized representative or the new person.

PLEASE PRINT IN INK

CA ① Name of Person Completing Form (First, Middle, Last)
FS

CA ② List new person in the home, including a newborn.
FS

NAME (First Middle Last)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
SOCIAL SECURITY NUMBER - -	BIRTHDATE - -	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	IS HE/SHE A PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
BIRTHPLACE (City/State/Country)	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	SCHOOL STATUS (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Not Attending School (Explain):	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		
RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER NAME USED: (Maiden, adoptive, etc.)	

CA ③ Has he/she applied for or received benefits in the past, such as: cash aid, food stamps, homeless assistance, Medi-Cal, Refugee Cash Assistance?
FS If "YES", explain: ☐ YES ☐ NO

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA ④ Is he/she a child under age 19? If "YES", complete below: ☐ YES ☐ NO

MOTHER'S NAME (✓) Lives in Home	FATHER'S NAME (✓) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Absence <input type="checkbox"/> Unemployment <input type="checkbox"/> Incapacity <input type="checkbox"/> Death

CA ⑤ Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? If "YES", explain: ☐ YES ☐ NO
FS

LIST NAME, BRANCH OF SERVICE, ETC.	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------------	---

CA ⑥ Does he/she presently live in California and intend to continue living here? If "NO", explain: ☐ YES ☐ NO

COUNTY USE ONLY

CASE NAME
CASE NUMBER
WORKER NAME
WORKER NUMBER
DATE RECEIVED

VERIFIED:	YES	NO
SSN		
FS ID		
Blind/Deaf/Disabled		
Residency		
DFA 285-C Comp.		
Referred to Cal-Learn		
CW 25 Completed		
CW 25 A Completed		
Referred to WTW		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		
Date of Entry to U.S.		
Excluded HH Member Code		
Work/Training/WTW Code		

CA ⑦ A. Is he/she a foster child(ren) living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO FS	COUNTY USE ONLY										
FS B. Do you want the foster child and their foster care income included in the Food Stamp case? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CalWORKs and FC Eligible/CR Chooses: Child: <input type="checkbox"/> CalWORKs <input type="checkbox"/> FC CR: <input type="checkbox"/> CalWORKs <input type="checkbox"/> None										
CA ⑧ A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO FS	VERIFIED: School Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No FS Eligible Student <input type="checkbox"/> Yes <input type="checkbox"/> No										
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM</td> <td style="width: 25%;">UNITS/HOURS PER WEEK</td> <td style="width: 25%;">EXPECTED DATE OF GRADUATION</td> <td style="width: 25%;">WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="4"> IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify): </td> </tr> </table>	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):						
NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO								
IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):											
CA B. Complete below if he/she is enrolled in college or attending a similar educational institution. FS											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter</td> <td style="width: 25%;">TUITION/FEES PER TERM \$</td> <td style="width: 25%;">BOOKS, EQUIPMENT, ETC., PER TERM \$</td> <td rowspan="3" style="width: 25%; vertical-align: top;"> VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td>ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)</td> <td>DAYS ATTENDING PER WEEK</td> <td>TRANSPORTATION USED</td> </tr> <tr> <td>TRANSPORTATION COST PER WEEK \$</td> <td>AMOUNT PAID BY CARPOOL MEMBERS \$</td> <td>PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$</td> </tr> </table>	TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No	ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED	TRANSPORTATION COST PER WEEK \$	AMOUNT PAID BY CARPOOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$	
TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No								
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED									
TRANSPORTATION COST PER WEEK \$	AMOUNT PAID BY CARPOOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$									
CA ⑨ Has he/she had cash aid or food stamps stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation? <input type="checkbox"/> YES <input type="checkbox"/> NO FS If "YES", complete below:											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">WHY</td> <td style="width: 25%;">WHEN</td> <td style="width: 50%;">WHAT COUNTY/STATE</td> </tr> </table>	WHY	WHEN	WHAT COUNTY/STATE								
WHY	WHEN	WHAT COUNTY/STATE									
CA ⑩ Is any member of the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? If "YES", give name of the person: <input type="checkbox"/> YES <input type="checkbox"/> NO FS											
CA ⑪ Has any member of the household been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s)? Give facts for cash aid, for convictions on or after 1/1/98; and for food stamps, for crimes and convictions after 8/22/96. If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO FS											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">NAME OF PERSON CONVICTED</td> <td style="width: 33%;">DATE CONVICTED</td> <td style="width: 34%;">DATE CRIME COMMITTED</td> </tr> </table>	NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED								
NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED									
FS ⑫ Does he/she buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO	Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No										
FS ⑬ Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO	Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No										
FS ⑭ Does he/she pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">Household Elects</td> </tr> <tr> <td style="width: 33%;">BOARDER</td> <td style="width: 33%;">HH MEMBER</td> <td style="width: 34%;">ROOMER</td> </tr> </table>	Household Elects			BOARDER	HH MEMBER	ROOMER				
Household Elects											
BOARDER	HH MEMBER	ROOMER									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">CHECK (✓)</td> <td style="width: 25%;">HOW MUCH</td> <td style="width: 25%;">HOW OFTEN</td> <td style="width: 25%;">NO. OF MEALS PER DAY</td> </tr> <tr> <td> <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both </td> <td>\$</td> <td></td> <td></td> </tr> </table>	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$					
CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY								
<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$										
FS ⑮ Does he/she get food from any of the following programs? <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> ● Communal dining facility for the elderly or disabled ● Food distribution program operated by a Native American reservation ● Other food program If "YES", complete below:											
NAME OF PROGRAM											

CA 16 Is he/she working now or expecting to be working in the next two months? If "YES", complete below. Attach paystubs or other proof of earnings. FS (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).						COUNTY USE ONLY <input checked="" type="checkbox"/> if Exempt <input type="checkbox"/> CA <input type="checkbox"/> FS Adult <input type="checkbox"/> FS Child FS S/E Farmer <input type="checkbox"/> Yes <input type="checkbox"/> No Verification(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMPLOYER NAME		SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		OCCUPATION		DAYS/HOURS WORKED PER MONTH	
PAY DATE(S)		WAGES BEFORE DEDUCTIONS \$ _____ per _____		TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO			
CA 17 A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? FS If "YES", complete below:						Child Care Informing Given to Client: Trustline Informing (CCP 2) <input type="checkbox"/> Yes <input type="checkbox"/> No Health & Safety Certification (CCP 5) <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Care Eligible CA <input type="checkbox"/> Yes <input type="checkbox"/> No FS <input type="checkbox"/> Yes <input type="checkbox"/> No	
NAME OF PERSON WHO RECEIVES CARE		NAME OF PERSON WHO GIVES CARE		MONTHLY AMOUNT PAID \$ _____			
NAME OF PERSON WHO RECEIVES CARE		NAME OF PERSON WHO GIVES CARE		MONTHLY AMOUNT PAID \$ _____			
CA B. Does he/she get child care costs paid for them? FS Include costs paid by a relative or friend, Department of Education, Student Aid, Block Grant, Cal-Learn, TCC, NET, WTW, SCC, CAAP, etc. If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF CHILD		WHO PAYS		MONTHLY AMOUNT PAID \$ _____			
NAME OF CHILD		WHO PAYS		MONTHLY AMOUNT PAID \$ _____			
CA 18 Has he/she stopped or refused work or training in the last 60 days? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM		Did this person get or expect to get wages or benefits this month? If "YES", complete below. <input type="checkbox"/> YES <input type="checkbox"/> NO				Emp. Statement Good Cause Determ Voluntary Quit <input type="checkbox"/> CA: 30 days <input type="checkbox"/> FS: 60 days	
		LAST PAYCHECK RECEIVED (DATE)		AMOUNT BEFORE DEDUCTIONS \$ _____			
		EXPECTED CHECK (DATE)		AMOUNT BEFORE DEDUCTIONS \$ _____			
		REASON FOR LEAVING JOB/TRAINING					
NUMBER OF HOURS OF WORK/TRAINING Last Month _____ This Month _____		LAST DAY OF WORK/TRAINING		TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO			
CA 19 Is he/she on strike? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM		NAME OF UNION				Striker Regs Apply CA <input type="checkbox"/> Yes <input type="checkbox"/> No FS <input type="checkbox"/> Yes <input type="checkbox"/> No	
		DATE WENT ON STRIKE					
		GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE \$ _____					
FS 20 Does he/she pay child or spousal support? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF CHILD OR SPOUSE		AMOUNT PER MONTH \$ _____		COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO		Court Order on File <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Ordered \$ _____	
CA 21 Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.?						<input type="checkbox"/> YES <input type="checkbox"/> NO	
FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE BENEFIT	AMOUNT \$ _____	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly, Etc.)	DATE EXPECTED TO START AND STOP START: _____ STOP: _____	<input checked="" type="checkbox"/> if Exempt CA <input type="checkbox"/> FS <input type="checkbox"/>

CA 22 Does he/she own or is he/she buying any real estate, such as land ☐ YES ☐ NO
 FS and/or buildings anywhere, including outside the U.S.?

If "YES", complete below:

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	ESTIMATED VALUE	AMOUNT OWED
			\$	\$

COUNTY USE ONLY

Home Exempt ☐ Yes ☐ No

Other Real Property

Market Value \$

Amount Owed \$

Net Value \$

Lien Applicable ☐ Yes ☐ No

CA 23 A. Does he/she have any of the following resources? ☐ YES ☐ NO
 FS If "YES" check (✓) each item and explain below:

RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) if Exempt
				\$	CA FS
				\$	

CA B. Does he/she get income from any of these resources, such as ☐ YES ☐ NO
 FS interest, dividends, etc.?
 If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA 24 Does he/she own, lease, or use any motor vehicles, such as a ☐ YES ☐ NO
 FS car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.?
 If "YES", complete below:

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
<input type="checkbox"/> Leased				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

(✓) If Exempt Leased ☐ Exempt ☐ Leased
 Vehicle Valuation

CA 25 Does he/she own or use personal property which cost at least \$100 for ☐ YES ☐ NO
 FS each item or is now worth at least \$100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do **not** list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings.
 If "YES", complete below:

OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED
			\$	\$
			\$	\$

☐ Owned Jointly
☐ Owned Separately
 Net Market Value \$

CA 26 Has he/she sold, transferred or given away any real or personal property ☐ YES ☐ NO
 FS within the last 2 years for cash aid and within the last 3 months for food stamps?
 If "YES", explain below:

Closed Bank Accounts:
☐ Food Stamps in last 3 months

CA 27 Does he/she have any of the following insurance coverage: life, burial, ☐ YES ☐ NO
 FS disability or mortgage?
 If "YES", complete below:

NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID
			\$

Total CSV
 (1) _____
 (2) _____
 Total Countable Property:
 Items 22-27
 CA \$ _____
 FS \$ _____

CA 28 Does he/she have health or hospitalization insurance, including insurance ☐ YES ☐ NO
 FS paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.?
 If "YES", complete below:

NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
		\$	

☐ Health Care Options
 Explanation Given
 Referral _____
 NA _____
☐ DHS 6155
☐ DFA 285-C
 Medicare Gross Premium \$

CA 29 Did he/she get medical/ pregnancy treatment this month or in the three months before this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					COUNTY USE ONLY																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">NAME OF PERSON RECEIVING CARE</th> <th style="width: 15%;">MONTHS OF CARE</th> <th colspan="2" style="width: 20%;">WAS PAYMENT MADE FOR TREATMENT?</th> <th colspan="2" style="width: 15%;">WANT MEDI-CAL FOR THOSE MONTHS?</th> </tr> <tr> <td></td> <td></td> <td style="font-size: x-small;">YES</td> <td style="font-size: x-small;">NO</td> <td style="font-size: x-small;">YES</td> <td style="font-size: x-small;">NO</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>					NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?				YES	NO	YES	NO													Retro Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No Approved <input type="checkbox"/> Yes <input type="checkbox"/> No							
NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?																																
		YES	NO	YES	NO																															
CA 30 Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					<input type="checkbox"/> DHS 6155																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">NAME OF INSURANCE COMPANY</th> <th style="width: 35%;">PREMIUM AMOUNT</th> <th style="width: 35%;">HOW OFTEN PAID</th> </tr> <tr> <td> </td> <td>\$</td> <td> </td> </tr> <tr> <td> </td> <td>\$</td> <td> </td> </tr> </table>					NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID		\$			\$																								
NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID																																		
	\$																																			
	\$																																			
CA 31 Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					VERIFIED: Higher/Lower MAP <input type="checkbox"/> Yes <input type="checkbox"/> No Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">TYPE OF PROBLEM</th> <th style="width: 30%;">DATE PROBLEM STARTED</th> <th style="width: 40%;">EXPECTED DATE OF RECOVERY</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>					TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY																													
TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY																																		
CA 32 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? FS Check (✓) each item YES or NO:					CA Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____ VERIFIED: CA <input type="checkbox"/> Yes <input type="checkbox"/> No FS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 30%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> </tr> <tr> <td>Special diet--prescribed by a doctor</td> <td></td> <td></td> <td>Very high use of utilities</td> <td></td> <td></td> </tr> <tr> <td>Special transportation need</td> <td></td> <td></td> <td>Special laundry service</td> <td></td> <td></td> </tr> <tr> <td>Special telephone or other equipment</td> <td></td> <td></td> <td>Other (specify):</td> <td></td> <td></td> </tr> <tr> <td>Housework (no one in the home can do it)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>						YES	NO		YES	NO	Special diet--prescribed by a doctor			Very high use of utilities			Special transportation need			Special laundry service			Special telephone or other equipment			Other (specify):			Housework (no one in the home can do it)							
	YES	NO		YES	NO																															
Special diet--prescribed by a doctor			Very high use of utilities																																	
Special transportation need			Special laundry service																																	
Special telephone or other equipment			Other (specify):																																	
Housework (no one in the home can do it)																																				
If "YES", explain:																																				
CA B. Does he/she get In-Home Supportive Services (IHSS)? <input type="checkbox"/> YES <input type="checkbox"/> NO FS If "YES", how much does he/she pay each month? \$ _____					<input type="checkbox"/> DFA 285-C																															
CA 33 The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility. Check (✓) each item YES or NO.					<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> Referral																															
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">YES</th> <th style="width: 50%;">NO</th> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>		YES	NO																												
YES	NO																																			
• Do you want more information about CHDP Services? • Do you want CHDP medical services? • Do you want CHDP dental services? • Do you need help making appointments or with transportation to CHDP Services?																																				
B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">YES</th> <th style="width: 50%;">NO</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		YES	NO																												
YES	NO																																			
C. Is anyone in the family breastfeeding a child? If "YES", was the birth within the last 12 months? If you checked "YES" to 34 B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">YES</th> <th style="width: 50%;">NO</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		YES	NO																												
YES	NO																																			
D. Do you or any family member want free or low-cost family planning services ? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">YES</th> <th style="width: 50%;">NO</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		YES	NO																												
YES	NO																																			
					<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date _____																															

CERTIFICATION

I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state, and federal personnel, and if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident alien (LPR), (b) an amnesty alien with a valid and current I-688, or (c) an alien permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the INS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of their parole or probation cannot get cash aid or food stamps.
- Anyone who has committed and been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) since August 22, 1996, cannot get food stamps or if convicted on or after January 1, 1998, cannot get cash aid.
- For cash aid and food stamps, the county will require that I and certain household members be fingerprint and photo imaged. All benefits may be denied or stopped if we do not cooperate.

I also understand that:

I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:
 - For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
 - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
 - For conviction of felony thefts to get aid: 2 years for theft of amounts under \$2,000; 5 years for amounts of \$2,000 through \$4,999.99; and forever for amounts of \$5,000 or more.
 - For giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than \$10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing: forever.

For food stamps:

- If on purpose I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
 - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
 - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second.
 - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever.
 - I filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps can be stopped for 10 years.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMPS AUTHORIZED REPRESENTATIVE)

SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)

DATE

SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY

DATE

NOTICE OF WITHDRAWN APPLICATION

TO:

Date: _____

Case Number: _____

County: _____

•

•

—

You told us on _____ that you wanted the County to stop your application for:

☐ CalWORKs☐ Food Stamps☐ Medi-Cal☐ Other _____

Because you asked, we did so.

You have the right to apply again at any time.

Worker Signature_____
Phone Number

Comments:

Although you have withdrawn your application, you and your family may be able to get family planning services. If you want help, ask the County or a family planning agency for more information.

SUPPLEMENTAL STATEMENT OF FACTS - MINOR PARENT

The Minor Parent Rule says you can get cash aid if you are under 18 years of age and have never been married and are pregnant or have a dependent child in your care, **only** if you and your child live with your parent(s), legal guardian, other adult relative, in a group home, or in a maternity home. Your cash aid will be paid to that adult.

The Minor Parent Rule may not apply if you meet one of the following conditions:

- 1) A child protective services worker determines that it's not physically or emotionally safe for you to live with your parent(s) or legal guardian; or
- 2) Your parent(s) or legal guardian is dead; or you don't know where they live; or they won't let you live with them; or
- 3) You have lived apart from your parent(s) or legal guardian for at least one year before the birth of your child or application for cash aid; or
- 4) You are legally emancipated.

- If you are living apart from your parent(s) or legal guardian, and one of the listed conditions applies, your case will be referred for minor parent services.
- For cash aid and food stamps, the county will require that you and certain household members be fingerprint and photo imaged. Your benefits may be denied or stopped if you do not cooperate.

Complete the questions below. If you need more space, attach another sheet of paper. If you need help, ask your worker.

① YOUR NAME (FIRST, MIDDLE INITIAL, LAST) _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ CURRENT ADDRESS (NUMBER, STREET NAME (AVENUE, BLVD, ETC.), APT. NO.) _____ PHONE NUMBER _____ CITY _____ ZIP CODE _____ MESSAGE PHONE NUMBER _____	COUNTY USE ONLY CASE NAME _____ CASE NUMBER _____ EW NAME AND NUMBER _____ PHONE NUMBER _____ REFERRAL FOR <input type="checkbox"/> RISK ASSESSMENT FOR SAFETY ISSUE <input type="checkbox"/> CalWORKs IMMEDIATE NEED <input type="checkbox"/> MINOR PARENT MEETS THE FOLLOWING EXEMPTION(S): <input type="checkbox"/> No living parent(s)/legal guardian <input type="checkbox"/> Parent(s)/legal guardian's whereabouts unknown. <input type="checkbox"/> Has lived on own for 12 mo. <input type="checkbox"/> Emancipated <input type="checkbox"/> Not allowed to live at home	② DO YOU LIVE WITH YOUR PARENT(S), OR A LEGAL GUARDIAN, OR IN A GROUP OR MATERNITY HOME? <input type="checkbox"/> YES If "YES", list who and relationship to you, and sign and date item ⑦ in the Certification Section. <input type="checkbox"/> NO If "NO", explain why not and for how long, and complete items ③ through ⑦. 												
③ NAME OF YOUR MOTHER (FIRST, MIDDLE INITIAL, LAST) _____ CONTACT PHONE NUMBER _____ CURRENT ADDRESS NUMBER, STREET CITY STATE ZIP CODE _____	REFERRED TO CWS ON _____ COMMENTS: _____ 													
④ NAME OF YOUR FATHER (FIRST, MIDDLE INITIAL, LAST) _____ CONTACT PHONE NUMBER _____ CURRENT ADDRESS NUMBER, STREET CITY STATE ZIP CODE _____														
⑤ DOES THE OTHER PARENT OF YOUR CHILD(REN) OR UNBORN CHILD LIVE WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER PARENT'S NAME (FIRST, MIDDLE, LAST) _____ DATE OF BIRTH _____ PHONE NUMBER _____ CURRENT ADDRESS NUMBER, STREET CITY STATE ZIP CODE _____														
LIST EVERYONE LIVING IN THE HOME. IF YOU ARE PREGNANT, LIST CHILD AS "UNBORN" AND GIVE DUE DATE. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">NAME OF YOUR CHILD</th> <th style="width: 25%;">DATE OF BIRTH OR DUE DATE</th> <th style="width: 25%;">SOCIAL SECURITY NUMBER</th> <th style="width: 25%;"></th> </tr> <tr> <td>NAME</td> <td>RELATIONSHIP TO YOU</td> <td>NAME</td> <td>RELATIONSHIP TO YOU</td> </tr> <tr> <td>NAME</td> <td>RELATIONSHIP TO YOU</td> <td>NAME</td> <td>RELATIONSHIP TO YOU</td> </tr> </table>			NAME OF YOUR CHILD	DATE OF BIRTH OR DUE DATE	SOCIAL SECURITY NUMBER		NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU
NAME OF YOUR CHILD	DATE OF BIRTH OR DUE DATE	SOCIAL SECURITY NUMBER												
NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU											
NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU											
CERTIFICATION														
<ul style="list-style-type: none"> • I understand I must meet the minor parent rule or an exemption to the rule to get cash aid. • I authorize the county to check and verify the facts I provided on this statement of facts. • I declare under penalty of perjury under the laws of the United States and the State of California that the information in this statement of facts is true, correct, and complete. 														
⑦ YOUR SIGNATURE _____ SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT _____	DATE _____ DATE _____	CWS: DOES SAFETY ISSUE EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO RETURNED TO EW ON _____ COMMENTS: _____ CWS SUPERVISOR _____ DATE _____ CWS WORKER NAME/NUMBER _____ CWS PHONE NUMBER _____												

PAYEE AGREEMENT FOR MINOR PARENT

COUNTY USE ONLY
CASE NAME:
CASE NUMBER:
WORKER NAME:

If you do not return this form by _____
you will not get cash aid.

SECTION A: PREGNANT OR PARENTING MINOR AGREEMENT

I understand that any cash aid I am eligible to get for myself or dependent child(ren) will be paid to my parent, legal guardian, or other adult relative, with whom I live. I give permission to give this agreement to the person named below.

NAME OF PROPOSED PAYEE	RELATIONSHIP
SIGNATURE OF MINOR	DATE

SECTION B: PAYEE RESPONSIBILITIES

The above-named minor has applied for California Work Opportunity and Responsibility to Kids (CalWORKs) for him/herself and/or his/her dependent child(ren). The minor has named you to serve as payee and receive cash aid payments. Payee responsibilities are listed below:

- I understand the payments I get for the person(s) in this case are to be used for their support. If I willfully and knowingly receive or use any part of the payment for any reason other than to support them, state law says I may be prosecuted for committing a misdemeanor.
- I understand that I am responsible to make sure the minor is given all information sent to me by the county for the minor such as monthly report forms, notices of action and informing notices. It is the minor's responsibility to complete any necessary forms by the due date.
- I understand that if the minor moves out of my home, I should notify the county within 5 days and any payments received after the minor moves out should be returned to the county.
- I understand that if I do not agree to become the payee it does not affect the eligibility of the minor and/or his/her dependent child(ren).

SECTION C: PAYEE CERTIFICATION

Check either (A) or (B) below and sign.

- ☐ (A) I understand the above facts and agree to act as the payee for the person(s) in this case.
- ☐ (B) I refuse to act as the payee for the minor listed above.

SIGNATURE OF PARENT, LEGAL GUARDIAN, OR OTHER ADULT RELATIVE	PHONE NUMBER	DATE
RELATIONSHIP TO MINOR		

CalWORKs BUDGET WORKSHEET

CASE NAME:					CASE NUMBER:					WORKER NUMBER:				
Payment Month <input type="checkbox"/> Exempt from MAP Cuts FAMILY MEMBERS		Check (✓) One												
		A	B	C	D	E								
		AU (Non MFG and Non-Penalized)	Penalized AU	Non-AU (If income counted or ineligible noncitizen)	MFG	Sanctioned								
TOTAL														
1. Maximum Aid Payment for Family Members (A & C)		\$												
a. Net Nonexempt Income (Enter 13k or 13o from Side 2)		-												
b. Special Needs (Other than HA) (A, C & D)		+												
c. Potential Grant		\$												
2. Maximum Aid Payment for Persons (A)		\$												
a. Special Need (Other than HA) (A & D)		+												
b. Subtotal		\$												
c. Aid Payment (Lesser of 1c or 2b)		\$												
3. MAP for Minor Parent's Eligible Child(ren) (If MP in AU). (If MFG child, don't include) (A)		\$												
a. Special Needs for Minor Parent's Child(ren) (A & D)		+												
b. Subtotal		\$												
c. Minor Parent Aid Payment (Greater of 2c or 3b)		\$												
4. Proration figure (Use 2c or 3c) Date:		x												
a. Prorated Aid Payment		\$												
5. Adjustments (Specify):														
a. Child Support Non-Co-Op 25% of Aid Payment		-												
b. Overpayments		-												
c. Cal-Learn Penalties		-												
d. Cal-Learn Bonus		+												
6. Adjusted Aid Payment		\$												
Payment Month <input type="checkbox"/> Exempt from MAP Cuts FAMILY MEMBERS		Check (✓) One												
		A	B	C	D	E								
		AU (Non MFG and Non-Penalized)	Penalized AU	Non-AU (If income counted or ineligible noncitizen)	MFG	Sanctioned								
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b. Subtotal		\$												
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a. Special Needs for Minor Parent's Child(ren) (A & D)		+												
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4. Proration figure (Use 2c or 3c) Date:		x												
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5. Adjustments (Specify):														
a. Child Support Non-Co-Op 25% of Aid Payment		-												
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c. Cal-Learn Penalties		-												
d. Cal-Learn Bonus		+												
6. Adjusted Aid Payment		\$												
Payment Month <input type="checkbox"/> Exempt from MAP Cuts FAMILY MEMBERS		Check (✓) One												
		A	B	C	D	E								
		AU (Non MFG and Non-Penalized)	Penalized AU	Non-AU (If income counted or ineligible noncitizen)	MFG	Sanctioned								
TOTAL														
1. Maximum Aid Payment for Family Members (A & C)		\$												
a. Net Nonexempt Income (Enter 13k or 13o from Side 2)		-												
b. Special Needs (Other than HA) (A, C & D)		+												
c. Potential Grant		\$												
2. Maximum Aid Payment for Persons (A)		\$												
a. Special Need (Other than HA) (A & D)		+												
b. Subtotal		\$												
c. Aid Payment (Lesser of 1c or 2b)		\$												
3. MAP for Minor Parent's Eligible Child(ren) (If MP in AU). (If MFG child, don't include) (A)		\$												
a. Special Needs for Minor Parent's Child(ren) (A & D)		+												
b. Subtotal		\$												
c. Minor Parent Aid Payment (Greater of 2c or 3b)		\$												
4. Proration figure (Use 2c or 3c) Date:		x												
a. Prorated Aid Payment		\$												
5. Adjustments (Specify):														
a. Child Support Non-Co-Op 25% of Aid Payment		-												
b. Overpayments		-												
c. Cal-Learn Penalties		-												
d. Cal-Learn Bonus		+												
6. Adjusted Aid Payment		\$												

BUDGET RECOMPUTATION

7. Actual Cash Aid Paid		\$
a. Adjusted Aid Payment (from line 6)		-
b. Subtotal		=
8. Actual Cash Aid Paid (use for O/P only)		\$
a. Child/Spousal Support Collected (Except for MFG)		-
b. Subtotal		=
9. Overpayment Amount (Lesser of Subtotal 7b or 8b)		\$
10. Underpayment Amount (If 6 is larger than 7)		\$
EW INITIAL AND DATE		AUTHORIZATION DATE

7. Actual Cash Aid Paid		\$
a. Adjusted Aid Payment (from line 6)		-
b. Subtotal		=
8. Actual Cash Aid Paid (use for O/P only)		\$
a. Child/Spousal Support Collected (Except for MFG)		-
b. Subtotal		=
9. Overpayment Amount (Lesser of Subtotal 7b or 8b)		\$
10. Underpayment Amount (If 6 is larger than 7)		\$
EW INITIAL AND DATE		AUTHORIZATION DATE

7. Actual Cash Aid Paid		\$
a. Adjusted Aid Payment (from line 6)		-
b. Subtotal		=
8. Actual Cash Aid Paid (use for O/P only)		\$
a. Child/Spousal Support Collected (Except for MFG)		-
b. Subtotal		=
9. Overpayment Amount (Lesser of Subtotal 7b or 8b)		\$
10. Underpayment Amount (If 6 is larger than 7)		\$
EW INITIAL AND DATE		AUTHORIZATION DATE

FINANCIAL ELIGIBILITY TESTS UPPERCASE LETTERS A - E BELOW REFER TO LETTERS AT TOP OF PAGE 1				
11. EARNINGS FROM SELF-EMPLOYMENT	PERSON 1 OR MONTH DESIGNATED BELOW IN #13 FOR THIS COLUMN	PERSON 2 OR MONTH DESIGNATED BELOW IN #13 FOR THIS COLUMN	PERSON 3 OR MONTH DESIGNATED BELOW IN #13 FOR THIS COLUMN	
a. Gross Business Income	\$	\$	\$	
b. Business Expenses <input type="checkbox"/> Actual <input type="checkbox"/> 40%	—	—	—	
c. Net Business Income (11a Minus 11b) (Enter/Include In 12a And 13d)	\$	\$	\$	
12. APPLICANT FINANCIAL ELIGIBILITY	PERSON 1	PERSON 2	PERSON 3	
a. Gross earned income of A, B, C, D, E	\$	\$	\$	
b. Minus earnings disregard (up to \$90 each employed person)	—	—	—	
c. Subtotal for each employed person	=	=	=	
d. Total countable earned income (add amounts in c from all columns)	\$			
e. Child/spousal support for A, B, (not C, D, E)	\$			
f. Minus child/spousal support disregard (up to \$50 per AU)	—			
g. Total countable child/spousal support	=			
h. Other unearned income of A, B, C, D, E, including child/spousal support for C, E (not A, B, D)	\$			
i. Total countable income (12d + 12g + 12h)	=			
j. MBSAC + Special Needs for A, C, D	\$			
k. Family meets applicant test (if j greater than i.) If yes, continue #13 below	<input type="checkbox"/> YES <input type="checkbox"/> NO			
13. RECIPIENT FINANCIAL ELIGIBILITY AND NET NON-EXEMPT INCOME COMPUTATION	Prospective / Initial Month _____ OR Retrospective Budget Mo. / Payment Mo.	Prospective / Initial Month _____ OR Retrospective Budget Mo. / Payment Mo.	Prospective / Initial Month _____ OR Retrospective Budget Mo. / Payment Mo.	
a. Total disability-based unearned income of A, B, C, D, E	\$	\$	\$	
b. \$225 disability-based income disregard	—	—	—	
c. Subtotal Non-exempt disability-based income (If positive amount, enter amount in 13i) (If negative amount, enter amount in 13e)	=	=	=	
d. Gross earned income of A, B, C, D, E	\$	\$	\$	
e. Remainder of \$225 income disregard, if any (enter negative amount from 13c)	—	—	—	
f. Subtotal earned income (13d minus 13e)	=	=	=	
g. 50% Earned income disregard (total in 13f divided by 2)	—	—	—	
h. Subtotal Net Nonexempt Earned Income (13f minus 13g)	=	=	=	
i. Nonexempt disability-based unearned income (enter positive amount from 13c)	+	+	+	
j. Other nonexempt income of A, B, C, D, E, including child/spousal support for C, E (but not A, B, D)	+	+	+	
k. Total Net Nonexempt Income for Grant computation (13h + 13i + 13j) (also enter in 1a on page 1, if financially eligible and not receiving direct child/spousal support)	=	=	=	
l. Child/spousal support for A, B, (not C, D, E)	\$	\$	\$	
m. Minus child/spousal support disregard (up to \$50 per AU)	—	—	—	
n. Total countable child/spousal support	=	=	=	
o. Total Net Nonexempt Income for recipient test (13k + 13n) (also enter in 1a on page 1, if financially eligible and receiving direct child/spousal support)	=	=	=	
p. MAP for A & C + Special Needs for A, C, D	\$	\$	\$	
q. Family meets recipient test (if 13o is less than 13p) If yes, continue with Grant Computation on page 1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

STATEMENT OF FACTS - HOMELESS ASSISTANCE

Important Information

- If you have no place to stay, have \$100 or less in resources and appear eligible for CalWORKs, you may be able to get Homeless Assistance payments for temporary shelter and permanent housing **once in a lifetime**, unless your homelessness is due to an exception. You must be seeking permanent housing (PH). While you are looking, you may get money for temporary shelter (TS). If you find someplace to live, you may get money for permanent housing (PH).
- Exceptions to the once-in-a-lifetime rule are homelessness due to: domestic violence, physical or mental illness, or uninhabitability of the home. These exceptions are limited to once every 12 months. Homelessness that is directly caused by a State or Federal declared natural disaster is also an exception.
- You may get temporary shelter (TS) payments for up to 16 days in a row. The first day starts when you get the first temporary shelter payment. If you stay anywhere for free, or somewhere other than a shelter or business which rents rooms, you can't get a TS payment, but the days count as part of the 16 days.
- To get TS payments you must rent from a person or place that is in the business of renting property.
- At the end of the 16 days, TS will stop. You will never be able to get TS again, unless you have an exception, even if you have not used up all the TS benefits.
- You will be asked to prove that your payments were spent on shelter. If you can't, future payments will go to a shelter landlord or others for you.

Instructions: Print all answers in ink. If you need help, ask your worker.

1. Name of Caretaker Relative (first, middle, last)

Message Phone	A	Social Security Number - -	B	Date of Birth Mo. ____ Day ____ Yr. ____
---------------	---	-------------------------------	---	---

2.A. What was your last address?

Number, Street City State Zip

B. Explain where you are staying now.

C. How long have you been there?

D. Do you pay for staying there? ☐ YES ☐ NO
If "YES," how much?

3. Explain why you have no place to live.

4. Are you seeking permanent housing? ☐ YES ☐ NO
Explain:

5. Do you get Cash Aid? ☐ YES ☐ NO
If "YES," in which county:

6. Did you get Homeless Assistance from any county at any time? ☐ YES ☐ NO
If "YES," complete:
Which county: When:

7. List all liquid resources you own (include cash, checks, savings or checking accounts, credit union accounts, etc.). List each item and give its value.

8. If you get Homeless Assistance, you may have the payment made out to you or given directly to a shelter, landlord or other for you. Check (✓) below to tell us how you want the payment made:
☐ To Yourself ☐ To a Landlord ☐ To a Shelter ☐ Other (explain):

COUNTY USE ONLY

DATE RECEIVED

C	CO	Aid Code	Case Number	AU
---	----	----------	-------------	----

D Case Name (Last, First)

E Date HA Authorized
Mo. ____ Day ____ Yr. ____

F Type of HA (check)
☐ Temporary ☐ Permanent
☐ TV ☐ PV
☐ TM ☐ PM
☐ TU ☐ PU
☐ TD ☐ PD
 Start Date: ____ Start Date: ____

Disposition:

- ☐ Shelter arranged prior to TS
☐ Vendor payment issued
☐ HA denied

Worker:

Total resource value:

CERTIFICATION

I understand that:

- Homeless Assistance Temporary Shelter (TS) and Permanent Housing (PH) payments are limited to once in a lifetime, unless I have a verified exception.
- There is a limit on how much Homeless Assistance I can get.
- I am required to give my Social Security Number, which will be used to check identity and verify that I am not getting aid in more than one case, one county, or one state.

I understand that I must provide proof that:

- I am homeless;
- I am homeless due to an exception, if I have already gotten homeless assistance.
- I used the TS payment for housing, and that if I cannot, I must have my homeless assistance payments made out or given to a shelter, landlord or to others for me.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this Statement of Facts - Homeless Assistance is true and correct.

SIGNATURE OF CARETAKER RELATIVE

DATE

CHILD SUPPORT — GOOD CAUSE CLAIM FOR NONCOOPERATION

I do not want to cooperate to establish paternity and to obtain support because it is not in the best interest of the child(ren) for whom aid is requested. Here's why: Check (✓):
I expect it to result in increased risk of **harm to the child(ren)**:

- A) ☐ Physical harm
B) ☐ Sexual harm
C) ☐ Emotional harm

I do not want to cooperate because:

- D) ☐ The child(ren) was conceived due to incest/rape.
E) ☐ Increased risk of **domestic abuse**.
F) ☐ Legal court proceedings are going on for the adoption of the child(ren).

G) ☐ I am working with a public or licensed private adoption agency that is helping me decide whether to keep the child(ren) or to place them for adoption.

H) ☐ I have other credible reason(s) for not cooperating. Explain: _____

COUNTY USE ONLY

CASE NAME

CASE NUMBER

DATE OF APPLICATION

CARETAKER RELATIVE (IF DIFFERENT)

RELATIONSHIP TO CHILD(REN)

NONCUSTODIAL PARENT/ALLEGED FATHER

NAME OF CHILD(REN) OF NONCUSTODIAL PARENT/ALLEGED FATHER

CERTIFICATION

I want to claim Good Cause for refusing to cooperate for the reasons checked above. I understand I may be asked to prove that I have Good Cause for refusing to cooperate.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained on this report are true, correct, and complete.

SIGNATURE OF APPLICANT OR RECIPIENT

DATE

EVIDENCE PROVIDED

- ☐ No investigation
☐ No evidence provided
☐ Birth certificate
☐ Medical records
☐ Court documents
☐ Social agency letter
☐ Mental health professional letter
☐ Sworn statement
☐ Other

CLAIM DETERMINATION - COUNTY USE ONLY

TO: **LOCAL CHILD SUPPORT AGENCY** THIS CLAIM IS FOR ☐ CHILD SUPPORT ☐ MEDICAL SUPPORT

GOOD CAUSE EXISTS AND IS BASED ON: (✓)

- A) ☐ Increased risk of **physical harm** to child(ren)
B) ☐ Increased risk of **sexual harm** to child(ren)
C) ☐ Increased risk of **emotional harm** to child(ren)
D) ☐ Incest or rape
E) ☐ Increased risk of **domestic abuse** to parent/caretaker
F) ☐ Legal adoption before the court
G) ☐ Preadoptive services
H) ☐ Other credible reason(s) for not cooperating

Explain good cause:

1. Request for Good Cause has been denied.

Give reasons:

2. Was determination based on physical harm without evidence? ☐ YES ☐ NO

3. Was determination based solely on examination of evidence without investigation? ☐ YES ☐ NO

4. May enforcement proceed without applicant/recipient participation? ☐ YES ☐ NO

CWD REPRESENTATIVE'S SIGNATURE

WORKER NUMBER

PHONE NUMBER

DATE OF DECISION

SUPERVISOR'S SIGNATURE

DATE OF DECISION

FOR RECORDER'S USE

RECORDING REQUESTED BY:

WHEN RECORDED MAIL TO:

FOR THE AMOUNT OF THE LIEN BALANCE CONTACT:

LIEN

On this _____ day of _____, 20____, I, _____,
(THE UNDERSIGNED)

grant the COUNTY of _____, a political subdivision of the State of California, a lien against the real property owned by me or in which I have an interest as described below. This lien is granted as security for the amount I owe the

County of _____ because of the agreement signed on _____, for myself, my spouse,
or my children beginning the _____ day of _____, 20____.

I hereby waive the defense provided by the statute of limitations.

This lien is binding upon myself, my heirs, executors, administrators, and assignees.

The following is a true and correct description of the real property owned by me or in which I have an interest:
(Attach additional pages if necessary)

NAME(S) OF OWNER(S) AS IT APPEARS ON THE COUNTY TAX ASSESSOR'S ROLLS

THE AUTHORITY FOR THIS LIEN IS FOUND IN WELFARE AND INSTITUTIONS (W&I) CODE 11257.5

SIGNATURE OR MARK	DATE	PRINTED NAME IN FULL
SIGNATURE OR MARK OF SPOUSE	DATE	SPOUSE'S PRINTED NAME IN FULL
SIGNATURE OF WITNESS TO MARK(S)	DATE	

NOTARIZATION

SEAL

STATE OF CALIFORNIA
COUNTY OF _____

On _____ before me, _____,
(Title and Name of Officer)

personally appeared _____

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal

Signature _____

REFERRAL TO LOCAL CHILD SUPPORT AGENCY (LCSA)*(Complete one form for each Noncustodial Parent or Alleged Father)*

		DATE OF REFERRAL																	
<input type="checkbox"/> TO LCSA REPRESENTATIVE		CASE NAME	AID TYPE/CASE NUMBER																
<input type="checkbox"/> FROM CWD REPRESENTATIVE CW # PHONE		APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO CHILD(REN)																
		MINOR PARENT'S NAME (IF DIFFERENT FROM APPLICANT/RECIPIENT)																	
A. This case is referred to you because: <input type="checkbox"/> Action is necessary to obtain: <input type="checkbox"/> financial support <input type="checkbox"/> medical support <input type="checkbox"/> paternity <input type="checkbox"/> Recipient is receiving direct support payments. Action needed to transfer payments to county. <input type="checkbox"/> Good Cause has been (see CW 51 attached): <input type="checkbox"/> claimed <input type="checkbox"/> granted <input type="checkbox"/> denied <input type="checkbox"/> Other (see comments) B. The following information applies to this case: <input type="checkbox"/> CA 2.1(Q) Questionnaire is attached. <input type="checkbox"/> Noncustodial parent has health insurance coverage. A copy of the DHS 6155 is attached. <input type="checkbox"/> Medi-Cal eligibility has not been determined. <input type="checkbox"/> Previously sanctioned/penalized; now agrees to cooperate/assign support rights. <input type="checkbox"/> Child no longer resides with recipient. <input type="checkbox"/> Medi-Cal Only <input type="checkbox"/> CS 909, Declaration of Paternity, is attached. <input type="checkbox"/> Other (see comments) <input type="checkbox"/> Lamb Case (minor parent not eligible as a dependent child: Family Code 4000) C. Applicant/recipient has not agreed to: <input type="checkbox"/> Assign: <input type="checkbox"/> financial support rights <input type="checkbox"/> medical support rights <input type="checkbox"/> Cooperate in: <input type="checkbox"/> obtaining financial support <input type="checkbox"/> obtaining medical support and/or <input type="checkbox"/> establishing paternity <input type="checkbox"/> Forward support payments. D. Penalty/Sanction <input type="checkbox"/> Penalty has been applied due to non-cooperation. <input type="checkbox"/> Sanction has been applied for refusal to assign rights.		E. TYPE OF APPLICATION <input type="checkbox"/> NEW <input type="checkbox"/> REAPPLICATION <input type="checkbox"/> ADD A CHILD <input type="checkbox"/> ICT <input type="checkbox"/> RENEWAL <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">NONCUSTODIAL PARENT'S OR ALLEGED FATHER'S NAME</td> <td style="width: 40%;">CHILD SUPPORT FILE NUMBER</td> </tr> <tr> <td style="height: 30px; vertical-align: top;">CHILD'S NAME</td> <td style="vertical-align: top;">DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES</td> </tr> <tr> <td style="height: 30px; vertical-align: top;">CHILD'S NAME</td> <td style="vertical-align: top;">DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES</td> </tr> <tr> <td style="height: 30px; vertical-align: top;">CHILD'S NAME</td> <td style="vertical-align: top;">DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES</td> </tr> <tr> <td style="height: 30px; vertical-align: top;">CHILD'S NAME</td> <td style="vertical-align: top;">DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES</td> </tr> </table> F. <input type="checkbox"/> APPLICANT PREVIOUSLY RECEIVED AID SPECIFY TYPE: <input type="checkbox"/> CASH AID <input type="checkbox"/> MEDI-CAL ONLY <input type="checkbox"/> TMC <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">PLACE (CITY, COUNTY, STATE)</td> <td style="width: 40%;">DATE LAST RECEIVED</td> </tr> </table> G. <input type="checkbox"/> INTER-COUNTY TRANSFER/INTERSTATE TRANSFER <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">FROM (COUNTY/STATE)</td> <td style="width: 40%;">PRIOR COUNTY'S CHILD SUPPORT FILE NUMBER (IF KNOWN)</td> </tr> </table> H. <input type="checkbox"/> CASH AID <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">APPROVAL DATE</td> <td style="width: 40%;">ONGOING CASH AID AMOUNT \$</td> </tr> </table> DISCONTINUANCE DATE		NONCUSTODIAL PARENT'S OR ALLEGED FATHER'S NAME	CHILD SUPPORT FILE NUMBER	CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES	CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES	CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES	CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES	PLACE (CITY, COUNTY, STATE)	DATE LAST RECEIVED	FROM (COUNTY/STATE)	PRIOR COUNTY'S CHILD SUPPORT FILE NUMBER (IF KNOWN)	APPROVAL DATE	ONGOING CASH AID AMOUNT \$
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<input type="checkbox"/> FROM LCSA REPRESENTATIVE PHONE																			
<input type="checkbox"/> Applicant/recipient <u>has</u> cooperated with the law. <input type="checkbox"/> Applicant/recipient <u>has not</u> cooperated with the law: <input type="checkbox"/> Did not appear and/or provide verbal, written or documentary information <input type="checkbox"/> Rescheduled appointment on _____ <input type="checkbox"/> kept <input type="checkbox"/> failed <input type="checkbox"/> Refuses to appear as a witness at court or other hearing <input type="checkbox"/> Refuses to transmit child support payment(s) received directly from the noncustodial parent <input type="checkbox"/> Other (see comments) <input type="checkbox"/> This is a notice of renewed cooperation. <input type="checkbox"/> Paternity <input type="checkbox"/> has <input type="checkbox"/> has not been established. <input type="checkbox"/> Support order established. <input type="checkbox"/> CS 909, Declaration of Paternity, is attached. <input type="checkbox"/> Other (see comments)		I. <input type="checkbox"/> MEDI-CAL ONLY <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">DATE MEDI-CAL BEGINS/CONTINUES</td> <td style="width: 40%;">DATE DISCONTINUED</td> </tr> </table> REASON FOR DISCONTINUANCE		DATE MEDI-CAL BEGINS/CONTINUES	DATE DISCONTINUED														
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Comments: